MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
Quality Assurance Division – Licensure Bureau
2401 Colonial Drive, PO Box 202953
Helena MT 59620-2953
FAX: (406) 444-1742

APPLICATION FOR MONTANA STATE HEALTH CARE FACILITY / SERVICE LICENSE
HOSPICE PROGRAM

Initial Application ☐ **Renewal Application** ☐

Hospice Program ☐ **Residential Hospice** ☐ **In-Patient Hospice** ☐

Facility Name: _____

Facility Street Address _____ PO Box: _____

City: _____ Zip: _____ County: _____

Facility Telephone Number: _____ FAX: _____

Facility E-mail / Web page address: _____

Operating Organization

Information on ownership, contract or lease agreement if operated by a person other than the owner:

☐ **If a partnership, firm or association, list below every member thereof.**

☐ **If a corporation, list below the names and address thereof and the names of its officers**.

☐ **If State Affiliated Organization, list below:**

NAME	ADDRESS

(Please attach additional sheets as needed.)

Name of person or persons under whose management or supervision the service will be conducted:

_____

_____

_____

MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Quality Assurance Division – Licensure Bureau

I certify that all information submitted to DPHHS is true and correct. This license application to operate a Hospice is hereby submitted under the provisions of MCA 50-5-101 through 50-5-231, and ARM 37.106.2301-2311.

SIGNED: _____ DATE: _____

TITLE: _____

ADDRESS: _____ CITY: _____ STATE/ZIP: _____

Enclose a check or money order payable to the *Department of Public Health & Human Services* to cover the license fee. The fee is determined as follows:

(a) Facilities with 20 or less beds (stations) = $20.00

(b) Facilities with 21or more beds (stations) = $1.00 per unit.

(c) Facilities with no beds=$20.00

This fee will be deposited in the State Treasury and is non-refundable.